

THE

MEDICAL AND SURGICAL REPORTER.

No. 1000.]

PHILADELPHIA, APRIL 29, 1876.

[VOL. XXXIV.—No. 18.]

ORIGINAL DEPARTMENT.

COMMUNICATIONS.

A CASE OF OVARIOTOMY.

BY R. STANSBURY SUTTON, A. M., M. D.,

Of Allegheny City, Pa.

Mrs. R. H., a native of Ireland, came under the care of Dr. Chesrown in August, 1875. I saw her with the doctor on January 21, 1876. She was a widow, aged 49; had borne three children, the youngest being 18 years old. Her labors were not difficult, and she had never miscarried. When 47 years old, she was menstruating, and received a severe fright; the flow suddenly ceased, and never returned. Two months after this occurrence she first detected "something growing in her left side." She was lying in bed, upon her right side; a sitting posture was tiresome, and locomotion difficult; her face bore an expression pathognomonic of ovarian disease. Emaciation was well marked, the skin moist, pulse 98, respiration 20, temperature 99. Her thoracic viscera were free from disease; the kidneys were secreting about 30 fluid ounces of urine in 24 hours, which upon cooling deposited urates, but was free from albumen and sugar; its specific gravity was 1.024. There was no disease of the lymphatic system. The tongue was slightly furred, the appetite morbid, digestion imperfect; her legs were oedematous; the left internal saphenous vein was varicose. Sleep was only disturbed by the frequent necessity to rise and empty the bladder. The abdomen was immense; its enlargement had been rapid and constant during the last two years. She had

been attacked with "colic" repeatedly. No movements had been felt, and no sudden change of shape had occurred. In the median line, below the umbilicus, which was level with the surface, were two marks of the trocar. The date of the first tapping was about December 1st, 1875; that of the second was January 16th, 1876. At the first 25 pounds of fluid were taken, at the second 28 pounds. This fluid had not been examined chemically or microscopically. The enlargement was general, but irregular. The superficial epigastric veins were very large. In the hypogastric region the skin was covered with patches similar to vaccination marks, *linæ albicantes*. There was no tenderness on pressure, and the outline of the growth was the circumference of the whole belly. The walls were very thin, and more movable at some points than at others. The growth was not uniformly soft; some areas gave distinct fluctuation, others a doughy, semi-elastic feeling; the latter occupied the left inguinal and adjoining half of the hypogastric regions. Two distinct accumulations are patent. The measurement is as follows:—

At umbilicus, around the body.....	40 inches
Just above umbilicus, around the body	41 "
From ensiform cartilage to umbilicus	7½ "
From symphysis pubis to umbilicus..	8½ "
From right supra-spinous process of ilium to umbilicus.....	9 inches
From left supra-spinous process of ilium to umbilicus.....	10 inches

Fluctuation is detected both by the vagina and rectum. A sound passed into the uterus 2½ inches; it was anteverted, and its fundus deviated to the right side. It was movable, and

independent of the growth. The tips of the fingers could be pressed in between the growth and the pubis. The mammary glands present no changes.

January 22. Three or four fluid ounces of a dirty brownish fluid were drawn off with the aspirator. This fluid was highly albuminous, and the microscope revealed in it the "ovarian cell," besides granular matter, pus corpuscles and epithelium. The diagnosis was a multilocular ovarian cyst, with a medium pedicle and some adhesions. We agreed to give her five grains of citrate of lithia and twenty grains of citrate of potassa every twelve hours, a liberal diet, and after each meal 2 grains of quinine, and 20 drops tincture ferri chloridi. In reply to her inquiry as to an operation, I told her it was possible, but hazardous; that she could not expect to live long, and that little could be done for her; that if an operation were performed, and proved unsuccessful, she would die sooner than if the operation were not performed; but that if it proved successful, she might live for years in comfort.

January 26. The kidneys have been very active. The urine, upon cooling, deposits but little urates. The abdomen is filling up more and more, Dr. Chesrown thinks more rapidly than after the first tapping. She says she has determined to take her chances in an operation. Her pulse is 96; temperature normal. As she is in as good condition now as her physician has ever known her to be, we must decide the question of operation. She cannot live long in her present condition, which will soon grow worse; with an operation she has a chance for life, but if it fails she will die but little sooner. I determined, after leaving her, that if I was satisfied with her condition on the evening of the 28th, with Dr. Chesrown's concurrence, I would operate on the morning of the 29th.

January 29. Operation. While the patient was etherized in bed by Drs. Chesrown and Brewster, the following gentlemen assembled in an adjoining room: Drs. James King, H. T. Coff, F. Lemoyne, W. S. Huselton, George Purviance, Potter, and English. The patient, well protected by woolen stockings and warm blankets, was placed upon the table at 10 A. M. Pulse 108; temperature 99. An oiled silk sheet with a central opening, 4 by 8 inches, was closely sealed to the surface of the abdomen. The bladder was now emptied with the catheter. Assisted by Drs. Chesrown, Purviance, Le-

moyne and King, I proceeded to operate, as follows:—An incision five and a half inches long, in the median line, was carried down to the peritoneum, which was divided upon the grooved director. The incision was now increased seven-eighths of an inch, terminating just below the umbilicus. The cyst now in view filled the incision, and upon its face were two wounds of the trocar, from one of which was oozing a fluid in a very fine stream. A metallic sound was now passed around the cysts, which were found to be free from attachments (save the pedicle) on the left side. With the sound, some anterior adhesions just above the wound were broken up, and strong adhesions demonstrated to exist high up. With the hand, some of these were readily separated. A Fitch dome trocar was now plunged into the presenting cyst. It became clogged almost immediately, and turning the dome from side to side did not remove the obstruction. The cyst wall, being friable, began to give way around the canula, and the fluid to escape. The assistants kept the lips of the wound and cyst in close apposition. The trocar was now withdrawn, and the cyst slit up with a probe-pointed bistoury. It was seized with strong forceps, and held well forward, while its contents poured over the oiled silk sheet into the tub. This cyst safely evacuated, a second came into the incision, and was emptied with an ordinary trocar of about two pints of pus-like fluid. A third, filled with colloid matter, was delivered entire. The pedicle was now clamped and cut off, and the free end of the cysts turned into a basin. The remaining adhesions were very strong, and attached to the lower border of the right lobe of the liver, to the transverse colon and omentum. They were broken up with the hand and the cysts turned out of the abdomen. The right ovary was healthy. Considerable bleeding followed. One vessel was tied, the ligature cut short, and left. The edge of the omentum was badly torn, and disposed to bleed after exposure for some time to the air. Outside of a small clamp, this portion was cut away. All oozing points were carefully sponged with warm water until all bleeding ceased. Two small clots were picked out with the fingers, and warm water was poured into the cavity of the belly, which was then carefully sponged out to the bottom of the pelvis. A brief delay was made here, to make sure that no further bleeding would occur. The pedicle was placed

in the lower angle of the wound, and the clamped omentum in the upper angle; the wound was then closed with seven or eight silver sutures and adhesive straps. The abdomen was well padded with raw cotton and surrounded with a flannel bandage. The patient, now conscious, was placed in bed, with a jug of hot water to her feet. Forty drops of McMunn's elixir of opium and a dessertspoonful of brandy were administered by the mouth. Pulse 85. She was now left to her nurse.

10 P. M. Twelve hours since operation. Pulse 104; temperature 99; respiration 20. She has slept some, and drank considerable barley water. The nurse has used the catheter twice. The urine is high-colored, deposits urates, and does not exceed six ounces in quantity. Has no pain. Says she is *hungry*. As no gas has passed the bowel, we confine her to barley water. Ordered citrates of lithia and potassa in full doses.

Jan. 30, A. M. Pulse 120; temperature 99½; respiration 24. No gas has yet passed the anus. She complains of hunger. Urine more abundant and clearer. Ordered milk and lime-water ad libitum. P. M. Pulse 144; temperature 98½. No pain. Ordered an ounce of whisky and two grains of quinine every two hours, with beef broth.

Jan. 31, 8 A. M. The nurse reports a restless night. Pulse 160; temperature 94; respiration 35. There is nausea, and the skin is wet. A careful examination of the abdomen does not reveal any evidence of hemorrhage. It is flat, yet everywhere resonant on percussion. There is entire absence of pain. No gas has yet passed the anus. She was carefully rubbed dry. Injections of beef broth, whisky and quinine were thrown into the rectum every hour, while ammonia was given by the mouth.

11 A. M. Pulse 152; temperature 94; respiration 36. Hot irons and jugs of hot water were kept about her constantly. An hour after this she began vomiting, and fifty-six hours after the operation she died. No post-mortem was permitted. If she died from shock, it came on late, as her condition twenty-four hours after the operation was better than we had reason to expect. If she died of hemorrhage into the abdominal cavity, it is a matter of regret that we did not have the opportunity of being assured of it.

Remarks on the character of the growth.—The diagnosis was a multilocular ovarian cyst,

which the operation proved to be correct. But in the fluid which escaped from the largest cyst, which was slit up during the operation, was found a roll of reddish-brown hair. In the wall of the cyst was imbedded a bone, resembling a lateral half of the inferior maxillary, containing one tooth. On the inner surface of the cyst was a patch of true skin, with a cartilaginous tubercle in its centre, which was surrounded with a sturdy growth of hairs. These elements proved, beyond doubt, that the growth was dermoid in character, interesting, inasmuch as this type of tumor occurs only about once in sixty cases. All the fluids, with the cysts, weighed 38 lbs, the cysts alone 5 lbs. From the cyst in which were found these dermoid elements, I drew fluid with the aspirator prior to the operation, and found in it the ovarian cell, also albumen. A portion of the fluid was examined by Dr. Peaslee and Dr. Drysdale; both confirmed the existence of the ovarian cell. I was at a loss to reconcile this fact with the following extract from Dr. Atlee's work on Ovarian Tumors, chapter iv, page 171: "The fluid in these cases is not usually coagulable by heat." Again: "It possesses none of the chemical and microscopical characteristics of ovarian fluid." With specimens of fluid, these facts were also communicated to Drs. Atlee and Peaslee. The following reply from Dr. Atlee I give in full:—

PHILADELPHIA, Feb. 12, 1876.

MY DEAR SIR:—Before leaving for Alabama and Louisiana, I have just time to acknowledge your letter to-day, and to say that the fluid sent to me contains the ovarian cell, but no indications of inflammatory products. The specimen is very interesting, and the question needs further investigation. Your case being a multilocular tumor, may perhaps explain all. It is not uncommon for the septi of polycystic tumors to rupture and form one cyst out of two or more, and thus pure ovarian fluid may have got across to the dermoid cyst. So few fluids of the dermoid cysts have as yet been examined, that no rule can be positively stated, and hence your case is one of peculiar interest. In great haste, very truly yours,

WASHINGTON L. ATLEE.

Drs. Atlee and Drysdale, the discoverers of the "ovarian cell," claim its presence only in pure ovarian fluid, and that it is always distinctive of ovarian fluid and of nothing else. Pathol.

gists, however, differ upon this point, as will be seen by the following letter from Dr. Peaslee.

29 MADISON AVE., NEW YORK,
Feb. 12, 1876.

DEAR DR. SUTTON:—I have received your letter of the 7th, and the fluid also which it describes, and reply to the former at my first leisure moment. I find in the deposit at the bottom of the fluid an immense number of *granular corpuscles*, which I think are *somewhat changed pus corpuscles*, with blood corpuscles much changed, and epithelium. I do not find any other corpuscle, nor plates of cholesterine, nor any crystals of hydrochlorate of ammonia, which are almost always found abundantly in ovarian fluid by drying the specimen on a glass slide. I did not test the fluid for albumen; it had undergone some degree of decomposition. I once met with an ovarian cyst with a dermoid cyst in its wall, not larger than a horse-chestnut. Understanding the dermoid to be congenital, as I have explained in my book on ovarian tumors, I concluded that the ovarian cyst subsequently developed pressed against the dermoid and raised it up, and carried it from its original position in respect to the ovary. As the hair, bone, and tooth show your cyst to be the true dermoid, I do not think the presence of the true "ovarian corpuscle" in it can be accounted for, except on the ground that it is *not always distinctive* of an ovarian cyst. As I hold, it is *not*, any more than Gluge's glomerule is. Taken, however, with other corroborative facts, it is a valuable aid in diagnosis. Yours truly, in haste,

E. R. PEASLEE.

We have here the views of two great American authors on the value of the ovarian cell as an aid to diagnosis, and the case in question, it is hoped, will prove additionally interesting from this fact, and encourage students of pathology to place the "ovarian cell," by careful research, in a permanent position.

A CASE OF COMPLETE ATRESIA VAGINÆ.

BY A. F. SHELLY, M. D.,
Of Philadelphia.

March 13th, 1874, I was called to see Miss Z., aged 15 years. I found her in excruciating pain, principally from inability to urinate; in attempting to draw off the water, I, to my sur-

prise, discovered a large tumor pressing upon the perineum, and separating the labia majora, like the size of a child's head in the last or expulsive stage of labor.

I then drew off the water, which gave immediate relief; but the tumor remained the same, with the exception, perhaps, of being not quite so tense; the perineum, however, was distended to its fullest extent; I now made a thorough examination of the parts, and soon discovered that no orifice of the vagina could be found; I now directed my patient to place herself upon her elbows and knees, and then, by introducing my index finger of the right hand into the rectum (finding a considerable amount of resistance) and the end of my thumb upon the external surface of the tumor, I found unmistakable fluctuation, by which I was at once convinced that its contents must be fluid of some kind.

Now for the diagnosis. What can it be? My next important step was to pry into the history of the patient's former condition, and by questioning both mother and child, I was told that the patient had complained, at monthly intervals, of pain in her stomach, and her mother thought she was lazy and indifferent; always had good appetite, and these pains were of short duration, therefore she did not make account of them, thinking also that the child had arrived at the age when a change should take place, as she had never been unwell yet; signifying that she had never menstruated. Those pains and slight indisposition at intervals, I traced back to nearly, if not quite, one year; the child was well developed, and, to all appearances, healthy.

Percussion was now made over the lower part of the abdomen, and I found dullness extending in an arc from the middle of Poupart's ligament on one side, to the same point on the other side, and arching up four inches above the symphysis pubis.

I now commenced sailing pretty clear as to diagnosis, and felt assured that I had, for the first time in my experience of twenty-four years' practice, to contend with an imperforate hymen; the vagina certainly, and the uterus probably, having been gradually filled to extreme distention by menstrual fluid, increasing at monthly intervals for about a year, without inconvenience, except being inclined to costiveness (which would necessarily follow), and the slight indisposition before mentioned.

This being the first case I ever saw of the kind, I determined to make haste slowly, and determined not to cut (because of the difficulties and uncertain results that often have followed such operations) without first consulting some one who would be willing to share the responsibility with me. I now called on my esteemed friend, Dr. Ellerslie Wallace, Professor of Obstetrics in the Jefferson Medical College, who very kindly responded, and at once coincided with me in the diagnosis. Our meeting took place on Saturday, the 14th day of March, 1874. After conversing together and citing different modes of treatment, and the danger, oftentimes resulting in death, from metritis, peritonitis, and pyæmia; this being also the first case Professor Wallace ever saw, he said: "I often thought, and have said to my classes, that if I should ever have a case, I would not cut open the vagina and syringe it, nor cut it open at all, but would puncture the hymen with a grooved needle, and await results." "Why not try it in this case, Doctor?" said I: "if you had not met me this morning here, I would have punctured it; and done no more."

Now, puncture we did; but let me impress upon the mind of the reader the manner of making that puncture. I did not thrust in a bistoury; the puncture was made with an ordinary grooved needle, held between the thumb and index finger, and, with its groove upward, introduced from below upward in an oblique manner, so as to form a perfect valve, for the purpose of excluding every particle of air. I lay great stress upon the mode of procedure, for in it, I verily believe, lay the whole secret of success.

I would here suggest an instrument to be made expressly for the purpose; let it be of the size of an ordinary grooved needle, rounded at the point, well-grooved, with very sharp edges, and you have all that you require.

After the puncture was made, a very dark, pitchy fluid was discharged, in a sluggish manner, to the enormous quantity of at least four pints, in the next twenty-four hours; after that the discharge appeared to be of a mixed, bloody mucus, and muco-purulent character, and continued to be so for the period of about three weeks; becoming, however, less, and more watery, and at last very trifling in quantity.

From the nature of the discharge we inferred, what we had rather anticipated from the beginning, that the lining membrane of the vagina

and uterus might have assumed a character somewhat resembling that of a cold abscess, into which had the air been admitted, metritis, and perhaps peritonitis, would almost assuredly have taken place.

The after-treatment consisted chiefly in keeping my patient in a horizontal position in bed, and under light coverings, within a temperate and well-ventilated room, keeping her bowels gently opened, and a light, nourishing diet, such as milk, broth, etc. I must, however, not forget to mention that, a few days after the evacuation of the pelvis, she felt inclinations to go to stool, with some uneasiness in her bowels; and I also found that her abdomen was fuller than I thought it should be, but without soreness on pressure, or the least febrile action. It occurred to me that there might be retained fecal matter, and by inquiring I was told that her discharge before the operation was of a ribbon-shaped appearance. I administered a few doses of *ol. ricini*, without effect; then resorted to injections, which, after a few had been given, composed of *ol. ricini*, terebinthine, and soap suds, had the effect of bringing away about a quart of fecal scybala. After that the abdomen assumed a pliable condition, and all went on well.

I kept her in bed and quiet until her next menstrual period, which took place April 7th, twenty-eight days from the time she first commenced to feel indisposed, which was on the tenth day of March (although I was not called to see her until the 13th, when symptoms became alarming). Her menses now came on quite naturally, and were allowed to flow through the puncture, with the exception of inserting the point of a bistoury, without cutting, however. No more pus passed away; only the natural menses of health were observed.

After the menses ceased flowing (which only lasted about four days), she was allowed to get up and go around the room, and gradually allowed a more substantial diet. The case was now left to take care of itself for about three weeks, and on the first day of May following we met again, and excised a circular portion of the hymen, in size to admit the index finger, the same being at least the sixth of an inch in thickness. We now deemed it advisable to explore the vagina, to learn the condition of that tube, and, as far as possible, that of the uterus also. Therefore, passing the index finger with great care and delicacy, we made a

complete examination by taxis, and found both the vagina and uterus to be normal in character and position.

The idea of postponing the excision was to wait until the second following period of menstruation, which would have a tendency to keep the orifice open. Instructions were also given to keep the orifice dilated with her own fingers for some time, to insure success. Perfect success followed, without one untoward symptom during the whole course of treatment. She has since menstruated regularly and enjoyed perfect health; and I have no doubt that if the same treatment be pursued in like cases, similar results will follow. Should such a case come under the charge of a professional brother, it would be gratifying to see it reported. I will now cite several authorities, to enable the reader to make comparison, at a glance, of the different modes of operation recommended.

Professor Meigs, "Woman and her Diseases," published in 1851, says: "Thrust a trocar through the membrane; when your trocar is withdrawn, and the detained menstrual fluid evacuated, pass a narrow straight bistoury, with a probe point, through the opened membrane, and cut it into four triangular flaps, carrying the incision nearly down to the level of the vaginal walls; and once in two or three days press through the opening thus made a silver gilt bougie, of proper size, so that when the cut edges are healed they may not leave a constriction of the vagina." (The books are full of such cases, which present very little interest, save that arising from the necessity of being careful in the diagnosis.) "There is no difficulty," he says, "in the treatment, either by the trocar or bistoury." Here Meigs ignores the dangers. But in his treatise on obstetrics, published in 1856, he says: "Open the hymen by means of a bistoury. If the womb should have been much distended by the collection, that organ immediately tends to contractions, that are felt in the same manner as after pains. It would be a prudent precaution, before doing this operation, simple as it is, to announce the no little risk that waits upon it, for it does sometimes happen that the abnormal state of the womb forces itself into a state of inflammation subsequently to the operation; and such inflammation may very readily assume the characteristics of mortal metro-peritonitis. I have done

this operation for several persons, and have had cause of serious concern during a few days subsequent to the drawing off of the long retained products, on account of a following inflammatory disposition in the woman."

Scanzone (1856) treated five cases. He "incised the membrane longitudinally, by means of a lancet, and there flowed out a considerable quantity of black blood. In three cases the flow lasted many hours after the operation, and was accompanied with quite violent expulsive pains;" and he also speaks of a girl of 19 years, suffering for two years with violent dysmenorrhoeic accidents, the cause of which was imperforation of the hymen, when during an access of colic this organ was suddenly ruptured, and allowed the escape of almost two pounds of fetid and decomposed blood. He says nothing of the dangers of the operation.

Churchill (1857) says: "We have merely to plunge a sharp-pointed bistoury through the membrane, at its upper part, enlarge it downward, making the opening sufficiently large, as it will contract afterward a good deal. Pressure should be made on the uterine tumor, until, by the evacuation of its contents, it disappears, and then a binder, with compresses, should be firmly applied.

"For a day or two we may allow the fluid to drain away quietly, but then it will be well to syringe out the vagina with warm water, and to introduce into the orifice a pledget of oiled lint, or a sponge tent, to prevent the orifice closing, etc. In many of these cases, if not in all, there is a disposition to peritoneal inflammation after the sudden emptying of the uterus, but this may be generally avoided by great care and quietness."

Erichsen says: "Incision of the membrane is the only remedy," and says nothing about the dangers.

S. Cooper ("Surgical Dictionary") says: "The patient may be easily relieved by a crucial incision, or by a simple cut, the edges of which are kept apart by a tent," and says nothing about the dangers.

Baker Brown (1871): "Divide the hymen by a crucial incision, and after the escape of the black, treacle-like, and fetid fluid, syringe the uterus well out, with warm water, and afterward apply a bandage around the abdomen. This appears very simple and easy, yet many young women have lost their lives from subsequent

peritonitis, and the subject is worthy of careful investigation."

Sims (1866) advises a simple puncture, with an exploring needle, leaving the gradual evacuation of the fluid to nature and time. The object of this is to allow the uterus time to contract, as its contents slowly ooze away. "I would give ergot, till its specific action was produced on the uterus," before the puncture, "for the purpose of insuring uterine contraction while the fluid was being evacuated. Against the crucial incision I would seriously warn the inexperienced, as, simple as the operation is, it is fraught with great danger, in consequence of a rapid evacuation of the retained fluid."

Atthill (1872) describes one (his only) case: "The fluid was first slowly and cautiously evacuated through a small canula; an exit was thus given to a large quantity of a dark, inodorous fluid, and subsequently the membrane was freely divided by a crucial incision."

Leischman (1873) alludes to imperforate hymen as "rendering an operation necessary, which is usually a very simple one," and says nothing of the mode of the operation or of its dangers.

West (1864) says, "a fatal result, due to inflammation, has sometimes followed an operation as simple as the mere division of an imperforate hymen; this has in some instances been produced by blood being poured through the fallopian tubes into the abdominal cavity, notwithstanding that an opening into the vagina existed, of ample size to allow of its ready escape in the natural way."

Byford (1865) advises to "tear through by pushing the index finger forcibly against the hymen. This failing, introduce an exploring trocar into the containing sac, and, guided by this, freely incise the most dependent part. The opening ought to be free, the blood all evacuated, and the cavity washed out with tepid water. The opening will have a tendency to close, and we can avoid this best by introducing the finger every day for two or three weeks. The injection must be repeated twice a day for the first ten days or two weeks. There is often a strong tendency to peritoneal inflammation soon afterward, which not unfrequently proves fatal. Pyæmia is another danger, and is to be avoided only by the thorough cleansing of the cavity I have described."

Hewitt (1867) suggests that an "opening just large enough to allow of the escape of a

very minute quantity of fluid be made at first, and that this opening should be made obliquely in the obstructing membrane, giving it a valvular character. The fluid should be evacuated guttatim. If the opening become closed, a second and similar opening to be made the following day, or two or three days later, and a firm but gentle support given to the abdomen by the aid of a bandage during the evacuation of the fluid. The aperture should not be incised until the uterus has returned to its proper dimensions."

Hutchison (1871) says, "the method of operating has usually been to make an incision of a crucial form, etc. Clinical experience has shown that it is attended by much danger to life. In a very considerable proportion of such cases peritonitis comes on, and death ensues. It may easily be supposed that the retained menstrual fluid is in a condition peculiarly apt to undergo decomposition as soon as air is admitted, and not unlikely, when decomposed, to induce a form of endometritis. Post-mortem observation has demonstrated that some of the retained fluid finds its way upward, through the fallopian tube, into the sac of the peritoneum. The fallopian tubes, as well as the uterine cavity, are often very greatly dilated. The uterus, by its contractions after evacuation, may possibly drive a certain portion of fluid backward. It may easily be supposed that the tubes, already distended and thinned, are unable to empty themselves quickly, whilst a powerful organ like the uterus excited to contraction by the escape of its contents would rapidly do so, and thus close the aperture of communication. I am not aware of any published cases of death after incision of imperforate hymen in which there was post-mortem proof that no escape of fluid into the abdomen had taken place. To make a very small incision, and thus allow the fluid to drain slowly off, instead of at once permitting the uterus to empty itself, has been proposed, and with much plausibility. Still it is probable that, however slow the escape might be, the uterus would act energetically throughout the whole time, thus preventing the evacuation of the thin and feebly muscular tube. With the view of retarding this action, it might possibly be well to put the patient, before the puncture, under the full influence of tartar emetic, and keep her nauseated for twenty-four hours afterward."

Barnes (1873) in contrasting the making of

"a very small opening in the hymen," with that of "a free incision at once, and even proceeding to wash out the cavity," says, "it is to be apprehended that cases will continue to occur in which a fatal result will follow any method of treatment. A plan which I should be disposed to try, is to draw off a little at a time by the aspirator-trocar, so as to effect a very gradual diminution of the cavity before freely dividing the obstruction.

"Death has followed both methods. I believe the opening should be sufficiently large to admit of easy evacuation, and that to prevent the entry of air, a compress should be applied over the uterus, and sustained by moderate pressure with a bandage.

"Injections have been used to wash out the uterus. It is doubtful whether this is a good practice at the time of the operation, but if there should arise decomposition, the gentle injection of a weak solution of permanganate of potash or carbolic acid will be desirable. After a few days it is proper to enlarge the opening by removing a circular piece of membrane, etc.

"Symptoms of peritonitis, indicating that retained fluid has suddenly escaped into the peritoneal cavity, have set in on the third or fourth day. The contraction of the uterus leading to this catastrophe does not take place immediately after the operation." He then speaks of a case where "a very small incision was made; the patient remained well for two or three days. Surgical fever set in, and in a few days she died. The autopsy showed that the interior of the distended uterus had become the seat of a very intense inflammation, which had spread thence and led to a severe and fatal peritonitis. This was probably set up by air getting into the uterus, and causing decomposition and septicæmia. It strengthens the argument for free incision and washing out the uterus."

Thomas ("Diseases of Women," 1874) says: "The sudden evacuation of menstrual blood, which has been for a long time imprisoned in the uterus and vagina, is always a procedure attended by danger." And he advises "the use of the aspirator to remove the fluid very gradually and not at one time. Once in three or four days a portion may be drawn off by aspiration, until the cavity is emptied. The sudden emptying of the uterus causes contraction of the fallopian tube, and emptying of the tubal contents into the peritoneum is the conse-

quence. The danger is diminished by gradual evacuation of the mass of blood in the uterus. Having very gradually drawn off all the blood which will flow, the action of the aspirator should be reversed, and the emptied cavity thoroughly and repeatedly washed out with warm carbolized water. Then the patient should be kept perfectly quiet in the horizontal posture, and under the gentle influence of opium and quinine, for four or five days." He adds, that "Bernutz practiced puncture by a very small trocar guarded by gold-beater's skin, to be followed after evacuation of all the retained blood, and diminution of the size of the distended uterus by an extension incision of the membrane and the employment of dilatation."

Thomas also speaks of "the array of fatal cases now on record from sudden evacuation," etc.

A volume of comments might be written upon the foregoing authorities, but I leave it to the intelligent physician to analyze them, and he will discover that all the good points are contained in the treatment described in my case. Suffice it to state what ought to be positively avoided.

First. Incision.

Second. Syringing, or washing out the vagina (unless for especial, untoward occurrences).

Third. Compresses, as they will in no wise tend to exclude air, and will only prevent nature from performing its proper function.

Fourth. By no means apply pressure for the purpose of expediting evacuation, as mischief is sure to follow, by bringing on premature and excessive action of the uterus, and forcing the contents back into the fallopian tubes, upon which so much stress is laid by some of the authorities quoted.

Fifth. Do not give ergot before the operation, for it is not necessary to arouse the energy of the uterus; nay, you may be glad if it does not arouse too suddenly; should it, however, do so, you must even meet it with proper agents, to subdue it.

Last and not least. Do not perform your final excision of the membrane until after the first period of a natural flow of the menses, when a sufficient portion should be excised, with proper instructions to keep the orifice well dilated, that final success may be assured.

A CASE OF SUPRA-PUBIC LITHOTOMY.

REPORTED BY C. W. DULLES, M. D.,
Of Philadelphia Hospital.

In response to a request appended to an article on supra-pubic lithotomy in the *American Journal of the Medical Sciences*, for July, 1875, Dr. Thomas W. Daring, of Chicago, has been kind enough to report to me the following case, which, with his consent, I now publish. It illustrates very forcibly the simplicity of the method, and the safety with which it may be practiced, under the most disadvantageous circumstances, by a man of skill and ingenuity.

I wish here to renew the request made last year, that surgeons who have time, and find it convenient, will report to me any cases done by them, or coming under their notice, which are not contained in the paper referred to, since the subject is still under investigation.

In April, 1870, while on the frontier, in Sedgwick county, Kansas, John Regan, a Texas cattle-driver, 46 years of age, was brought into camp. He was the subject of recurrent spasms (by recurrent spasms, I mean that before one paroxysm would entirely cease another would supervene). From his attendant I learned that about six hours previously he had been struck in the perineum with the pommel of his saddle, and that he was subject to "sudden stoppages" of his urine, which were followed by slight spasms. Introduction of the catheter and rectal examination revealed the presence of a cystic calculus, and bilateral prostatic enlargement. Morphia and chloroform failing to give relief, I determined upon operating. Having no instruments with me save those contained in a pocket case, I was perplexed. My thoughts were at first entirely directed to the perineal operations, thinking that I might use my combination catheter as a staff, and trust to my fingers and a pair of fair-sized polypus forceps for extraction. This plan, however, presented little prospect of feasibility, to say nothing of success. Thus perplexed, I began to review in my mind the anatomy of the several approaches to the bladder, and resolved to extract the stone from above the pubes.

The patient being on the ground, I removed the hair from the pubic region as best I could, with scissors; made an incision about three inches long through the linea alba, down to the

distended bladder, which I secured with a tenaculum, and then drew off its fluid contents, amounting to about two pints, with a small exploring trocar. The bladder was now opened with an incision about an inch long, the index finger introduced to ascertain size, position, etc., of the calculus. Two calculi were found, and extracted with the polypus forceps. One of these weighed three drachms one scruple, and the other five drachms fourteen grains. On examination, they were found to be parts of a single calculus, which had been fractured by the blow on the perineum.

The bladder was cleansed with tepid water, and its edges brought together with a glover's suture of one strand of ordinary silk. The wound in the abdomen was closed with five deep interrupted sutures, and water dressing applied. Prior to closing the bladder, I found that by bending the catheter slightly in the region of the fenestra, so as to approximate, in a measure, a prostatic catheter, it could be passed into the bladder, and I depended upon its use to empty this vessel. After the operation his urine was drawn off at intervals of six hours, and the bladder washed out each time before the catheter was removed. The syringe for this purpose was constructed of a rubber tobacco-pouch and the canula of my exploring trocar.

The case progressed favorably, without any back-set, despite the disadvantages under which the patient labored. On the fourteenth day he left camp with his friends, free from any vesical disturbance, save what would be attributed to the prostatic trouble, and, as he expressed himself, "good for forty-six years more."

The entire calculus was rough, oval in shape, somewhat flattened on the two sides, and consisted of concentric layers of uric acid, around a smaller oxalate of lime nucleus.

SALICINE IN OTORRHOEA.

BY E. H. JACKSON, M. D.,
Of Lancaster, O.

Every physician is aware that the success attending the treatment of ulceration of the ears, or of chronic otorrhœa, is not the most flattering, varied as the resources may be. With myself anything but a justifiable result in most cases was obtained, until I chanced to adopt salicine and calcined magnesia in combination. To the former of these I attribute the curative

power, though the latter is an excellent therapeutical adjuvant.

My experience with these remedies has been considerable, and I have yet to see the first case devoid of benefit. Of course there are some ear cases (as in all other classes of diseases) that cannot be relieved by any remedies so-called, but I am persuaded that by these means they are made to decrease in numbers. My method of treatment is as follows:—Ascertain the difficulty, its extent, nature, and state, either by natural or artificial examination, preferably the latter, i. e., by the otoscope, speculum (Wilde's), mirror, etc. By these means you are better able to begin treatment intelligently. Prior to each examination and application, syringe the ear well with tepid water; this may be soapy or clear; it should be soft water. Exercise care in this, as there is danger in undue pressure of the water upon the ear as it leaves the syringe. Place the syringe so that regurgitation may be unobstructed, and yet so that the water may freely reach the interior. After the ear is thoroughly cleansed and a speculum adjusted, blow into it through a quill—

R. Salicine,	gr.ij
Cal. magnesiae,	gr. iv.

and insert a small piece of cotton. Should the discharge be excessively offensive, the cotton can be wet with chlorinated soda, which will tend to allay the fetor. This process should be renewed every two or three days, observing well the effect, and varying the proportions of the medicine as demanded. In general, constitutional treatment is unnecessary, unless the otorrhoea depends on some dyscrasia. Much good, in the above procedure, attends the use of the water injections, but it is only a modicum compared with the salicine and magnesia. I am satisfied, patient, continued use of these means will meet the desires of many who have hitherto been disappointed.

Painful Points in Neuralgia.

More than a score of years ago, M. Valleix, the distinguished author of the "Guide du Medicin Practicien," called attention to the frequency of vertebral points *douloureux* in neuralgia, and the necessity of directing the treatment to them. Prof. Duplouy, of Bordeaux, now publishes the particulars of three cases of neuralgia that resisted all other treatment, and eventually rapidly subsided after the application of blisters to these points.

MEDICAL SOCIETIES.

INTERNATIONAL CONGRESS OF MEDICAL SCIENCES, BRUSSELS, 1875.

ABSTRACT OF THE SECTION OF OTOTOLOGY.
(Translated* and Epitomized for the MEDICAL AND SURGICAL REPORTER.)

President, Dr. Delstanche, Sr.
Secretaries, Messrs. Delstanche, Jr., and Ledeganck.

The first meeting occupied two hours and a half, with a short address by the president, in which he remarked he was happy to be able, after the Government and the municipality, to wish, in his turn, a welcome to the associates who had been willing to come to the Congress at Brussels.

He deplored the absence of the German physicians, detained at the Congress at Gratz, and who would have contributed largely to raise the éclat of their scientific debates; he presented their regrets, and expressed the hope that they would be able to assist, in full force, at the next reunion; nevertheless, the presence of some eminent specialists from Italy, France, Holland, and Russia, allowed him to hope that the session which opened to-day would not be fruitless in its results.

The president, after having declared the mission of the Provisionary Bureau terminated, proposed to pass immediately to the installation of the Definite Bureau.

According to the advice of the assembly, the Provisionary Bureau is maintained in its functions.

Messrs. Guye, of Amsterdam, and Sapolini, of Milan, were named honorary presidents.

The meeting adjourned, after a session of three hours and a half.

MEETING, SEPTEMBER 20th.

The meeting lasted eleven hours. President, Mr. Guye.

The first order of the day was the reading of the report of Mr. Delstanche, Senior, "Upon the means of measuring the hearing, and of recording the degree in a uniform manner in all countries."

The following conclusions were arrived at in the report.

1. In its normal state, the ear perceives equally well all sounds that strike it, whatever may be their motive. Consequently, a simple single toned "*acoumetre*" might be used as a common measure of the hearing in all lands.

In its pathological state, on the contrary, the hearing varies with the individual case; the deafness is sometimes partial and exclusively for certain sounds and certain isolated tones, as if some of the keys in the acoustic apparatus were lost out; in other cases it is more general, and is more or less impaired for all sounds. In such cases it is evident that a mono-toned

* Archiv für Ohrenheilkunde, Bd. x, heft iv, Leipzig, 1876.

"acoumetre" would not suffice; the examination cannot be complete without the aid of different "acoumetres," or better, one instrument combining the various acoustic elements, such as sounds and tones of varying height or intensity, isolated or combined among themselves, according to the desire of the physician. That one of which we have just given a description unites these conditions in a certain measure, but it will be a long time before we are able to arrive at an imitation of the human voice; the examination with the voice will be an indispensable complement of all artificial tests.

2. The metre ought to be our standard for measuring distances. If the "acoumetre" is not heard at a distance, the methodical employment of the diapason would give a more or less exact appreciation of the degree of hearing.

3. Numbers of formulæ for registration have been proposed, but so far as precision and conciseness are concerned, no one of these are equal to the abbreviated method in use for indicating the frequency of the pulse, respiration and temperature of the body. Represent, for instance, the words watch, timber, voice, ear right and left, by their initials; the distance the patient can hear the watch, and the distance it should be heard, by means of metres and centimetres.

Mr. Guye presented a communication "On the Danger of Respiration through the Mouth," with reference to the integrity of the ear. He mentions the fact that in medical literature but little notice is taken of the injurious practice among the deaf of breathing through the mouth. He also states that the nasal breathing fulfills certain indications which the buccal breathing cannot. They are threefold. 1. The sense of smell obviates the introduction of impure air. 2. The moisture of the nasal walls gives a certain degree of aqueous saturation to the inspired air, thus rendering it less irritating to the mucous membrane of the throat and larynx. 3. The inflexibilities of the nasal organs serve to catch the particles of solid matter suspended in the air, this being proved by the quantity of dust sometimes found accumulated in the nostrils. These points show the defects in the buccal respiration.

The contact of dry air often produces disorders of circulation in the region of the pharynx, particularly chronic catarrh, which may easily be transmitted through the Eustachian tubes to the tympanum.

Granular or adenoid pharyngitis may originate from this cause.

In order to overcome these conditions, it is very necessary to re establish the respiration through the nose. When we cannot do this through the will of the patient, as for instance in children, it is recommended to make use of a little apparatus something like the English respirator, except that it does not allow of the passage of air. Mr. Guye cites cases of deafness from catarrh which have been much relieved by the use of this method alone.

M. Bonnafont read a paper "On the Legal

Responsibility of Deaf Mutes." He began by establishing the fact that the absence of the sense of hearing exercises a most deleterious influence on the development of our faculties, and renders difficult all means of instruction and education. The intelligence of the deaf mute not being accessible to abstract ideas, we cannot expect to find in them a notion of conscience which permits the appreciation of the acts emanating from the intelligence. He refuses to admit that the deaf mute is capable of receiving an unlimited amount of education, and thinks, at best, that it can only be an *approach to an education*. Again, in this respect, it is necessary to make a distinction between congenital and acquired deaf-mutism. Between the uninstructed deaf-mute and the idiot, there is not much difference. M. Bonnafont endeavors to prove that the deaf-mute is devoid of dangerous propensities, quoting Itard, who declares that he has never seen a single deaf-mute become insane. Now, as this imbecility is in direct opposition to intellectual development, we have furnished a new argument in reference to the legal responsibility of those affected with deaf-mutism. This failing in the education of the intelligence belonging to them, makes itself felt through phases of their lives. If they learn to write, they generally make attempts in a childish or idiotic language, which shows an absence in precision of judgment. Then, he believes that legally the deaf-mute should be treated as the idiot. It has always been considered that deaf-mutes should be excluded from general social life. The ancients, believing that such conditions resulted from consanguineous marriages, prohibited such by law. Those laws, though sometimes severe, were nevertheless a blessing to humanity, as a check on the deterioration of the species.

Communication by Mr. Sapolini, on "Instruments for Extracting Foreign Bodies from the External Meatus."

He demonstrated the inefficiency of the instrument in general use, and exhibited an instrument of his own invention, which possessed all the requisites of such an apparatus, without the defects of other instruments. It is composed of two curved blades, one finer, the other capable of rotating on its own axis. They fit closely on each other, in a cylindrical tube of sufficient length. The blades fit in each exactly, so as to make but twice the thickness of one. They are passed so closed along one surface of the foreign body, and then the movable one made to describe a semicircle about it, so that the body is held between the blades, as in a pincette.

A more detailed description is found in a brochure of the author, "Nuovo Instrumento per l'estrazione dei Corpi Stranieri del Condotto Acustico Esterno."

M. Bonnafont presented his "New perforator for the membrana tympani." He mentioned the value of perforation, comparing it with the operation of cataract in eye surgery. He spoke also of the difficulty in keeping the

opening patulous. The instrument consists of a trocar armed with a little movable eyelet of aluminium, to which is fastened a thread which passes out through the meatus, by which the eyelet may be withdrawn if it become displaced; after perforating the membrane with the trocar, the eyelet remains fixed in the opening, by means of a little circular plug which opposes its displacement.

Mr. Van Hook presented a communication on salicylic acid. This agent has been employed by him with great success in all cases of inveterate otorrhoea. He had seen cases when the discharge had continued in spite of the employment of other most highly recommended remedies, and then disappeared, as if by magic, under the salicylic acid. Without pretending to decide positively as to the mode of action of this remedy, he is inclined to attribute the success obtained to its action on the bacteria and vibriones, similar to that of the acid phenique, but more certain in its action, and not presenting the inconvenience in the penetrating odor, so disagreeable to the majority of patients. The speaker extolled the use of this new agent, especially for those cases which the physician can only see at certain intervals of time. He makes use of a solution of one per cent.

Mr. Ogston observed that the acid is advantageously dissolved with borax.

A discussion ensued among the members of the society as to their preference for the various topical applications, each application having its advocate. Considerable variation in opinion as to the quantity of salicylic acid was expressed.

Mr. Ledeganek moved that, owing to the uncertainty in regard to the use and action of the acid, further consideration of it be postponed until the next session of the congress.

Mr. Guye concurs in the above, inasmuch as the subject has no special application, but belongs to general surgery and medicine.

Mr. Ogston believes that the salicylic acid does not interfere with the healing or cicatrization of the sore, while the acid phenique does present this inconvenience.

SEPTEMBER 25TH.

M. Delstanche again brought up the subject of deaf-mutism.

Those who claim for these unfortunates a certain degree of responsibility (in accordance with their education) do not take sufficiently into account the special condition in which they live. One does not take into account their irascibility; on the slightest provocation they often fly into the most violent rage. Again: there are many of them epileptics. M. Bonfont remarks that among some people they are banished from all society, while in other lands they are looked upon with a sort of veneration. The deaf-mutes of our country places are infinitely to be preferred to those found in the great centres of population.

Mr. Ogston made some remarks on M.

Wreden's observations, concerning the entrance of air into the middle ear at time of birth. It is said that on examining the cavity in a foetus at term, the cavity is filled with a sort of gelatinous substance, which disappears gradually as the air penetrates the middle ear, during the efforts at respiration. The medico-legal importance of this point Mr. Ogston has been developing by means of personal research. Up to the present time the observations embrace ten or twelve cases; four in which life had ceased on the first day, six or seven in which death had followed in from one to three weeks. The results were very diverse. In the one child dying the day after birth, the cavity was found nearly empty, while in those of two or three days old there was considerable gelatinous substance, and scarcely any air; so that, though this condition has no absolute value, it is still a positive sign that life has been there. As to the absence of air, we must bear in mind that it might have been excluded by imperforate Eustachian tubes.

Mr. Delstanche, Jr., remarked that Mr. Wendt, of Leipzig, had made still more recent observations on over three hundred ears of foetus and new born children. To account for the disappearance of the gelatinous substance in the still born, he allows the possibility of intra-uterine respiration.

Mr. Sapolini offered to the assembly the following propositions:—

1. He wished to see established an international investigation, concerning the statistics of deaf mutes in all countries. The investigation to occupy itself not only with deaf mutes, but also to include cases of simple deafness, and mutism, of which he knew, himself, two instances, and also cases of stammering. These two last being so intimately connected, and having their origin in the same primary lesion of the nerve of Wrisberg. Mr. Sapolini considers the nerve as the thirteenth cranial, having for its special function the articulation of words.

2. Mr. Sapolini wished that the efforts made by Mr. Delstanche, Sr., to secure to the profession a universal "acoumetre," might be continued. Mr. D. has demonstrated a scientific basis for its construction, and he desires that his efforts may be crowned with success and his wishes result in an established fact.

Jaborandi in Colds.

A French writer suggests that we are now in possession of a medicine which is destined to render signal service in colds. It is jaborandi, which, by its sudorific properties, and by its exciting action on the glands of the air passages and salivary glands, combines the principal pharmacodynamic effects that have heretofore been sought from various medicines. An infusion of one drachm of the leaves in a small quantity of water constitutes an efficient means against colds, if taken early.

EDITORIAL DEPARTMENT.

PERISCOPE.

The Temperature of Paralyzed Limbs.

The *Doctor* quotes some remarks by Professor Schiff, on this subject, from *Lo Sperimentale*. The investigations were commenced owing to the peculiarities observed in a case of injury of the spinal cord, with paresis of the right leg. The temperature was observed to be several degrees lower in the paralyzed leg than in the healthy one. The latter sweated profusely, the other not at all. The converse of this state of things has been often noticed. Prof. Schiff's experiments show that a dilatation of the blood-vessels, with considerable increase of temperature, follows section of the nerves of the vessels of a limb; but the increase at the end of two or three days is scarcely $\frac{1}{10}$ or $\frac{1}{15}$ what it was at first, and the fall is rarely delayed for a week. The fall of temperature thus takes place at a period when there can be no question of regeneration of the divided nerve. But the fall is never so great that the temperature of the paralyzed limb is not higher than that of the healthy one.

How is this decrease of temperature in the first few days to be accounted for? Schiff considers it to be probable, or almost certain, that just as the motility and sensibility of any particular region are supplied through several nerves, so there are several vaso-motor nerves regulating the same district. If, for instance, a sensory nerve be divided, it will be found that the portion of the skin which had lost its sensibility will recover it, after a few hours, or at longest a few days, over the greater part or the whole of its extent. This can only be explained on the supposition that the central organ has lost its perception of stimulation through the failure of action of one nerve, but that after some time it becomes accustomed to the diminished stimulation, just as the retina after being exposed to bright light only gradually becomes accustomed to the dark. The very same conditions hold good for motor and for vaso-motor nerves, and we thus obtain an explanation of the fact that the temperature after section of vaso-motor nerves is at first much higher than subsequently.

Observations of the temperature of paralyzed limbs (spinal paralysis) may therefore give different results according to the time at which they are taken.

From further most elaborate observations, continued day and night, Schiff has shown that the temperature in paralyzed extremities is subject to certain variations independent of the temperature of the body and of the surrounding medium. Two or three such may occur in twenty-four hours. In paralyzed limbs, sub-

jected to the same injuries, these variations are not always parallel; while one is very warm, the other may be cold. If only one limb is paralyzed the healthy one will also exhibit changes of temperature, which, however, are far more rhythmical than in the paralyzed limb. In general these changes are more limited in the paralyzed limb; when there is fever the temperature of the affected limb is not so much increased as in the healthy one. The complete loss of motion of the paralyzed limb may tend to diminish its temperature. As well as inflammatory processes in the central mass, which cause considerable loss of temperature in the paralyzed limb by irritation of the vaso-motor nerves.

The Varieties of Phthisis.

The following classification is made by Dr. J. E. Pollock, in a clinical lecture published in the *Lancet*:—

Acute tuberculosis.

1. Passive invasion of the whole lung by miliary tubercle.
2. Progressive deposits; rapid softening. Simple alveolar catarrh.
1. Cellular products expectorated (recovery).
2. Alveolar products soften; collapse of walls (recovery).
3. Alveolar products remain, become caseous, cretaceous (obsolescent tubercle).

Catarrhal pneumonia, }

Broncho-pneumonia, }

Lobular pneumonia. }

Alveolar walls, lung-tissue destroyed (cavity).

Lymphatic phthisis, }

Adenoid (Sanderson), }

Tubercle (Laennec). }

Overgrowth of lymphatic tissue; lobular pneumonia deposits; softening; vomica.

Fibroid phthisis.

Of various origin. Interstitial fibrous growth; contracted lung (chronic phthisis).

He quotes Stokes' remark, that "localized bronchitis with dullness is phthisis," and adds, "so is localized pneumonia, which does not clear up within a certain time."

Simple alveolar catarrh derives its importance from its being limited. Spread over a whole lung, or both, it is bronchitis. It is often insidious. Catarrhal pneumonia is accompanied by a greater exudation of inflammatory products; here is broncho-pneumonia or lobular pneumonia. The alveoli suffer, their walls break down, and we have a cavity, but, according to modern pathology, there may be no tubercle. At the same time, these are the changes so well described by Laennec. Lymphatic phthisis he classes with Sanderson's adenoid. Overgrowth, under irritation of the

adenoid tissue, is capable of fatty degeneration, breaks up, liquefies, is removed, as seen in external glands. It is also capable of fibrous transformation. But, apart from theory, Dr. Pollock thinks the destructive forms—lymphatic, ordinary tuberculous, or pneumonic, including what was formerly called struma—comprising most cases of ordinary phthisis, group well together. *Fibroid phthisis*, he considers, includes several varieties, and chronicity is its character. In fact, it is only chronic phthisis that gives time for fibroid changes.

The Eucalyptus Globulus as a Cancer Remedy.

The profession may well look with distrust on alleged "cancer cures," but the journalist must not omit to mention them. The latest is the famous *eucalyptus globulus*. The *Doctor* quotes six cases reported by Prof. Luton, of Reims, in the *Progres Medical*, all successful; and, as Prof. Luton is a respectable practitioner, and the subject most interesting, we give them:—

The first case was that of a woman, 78 years of age, suffering from an encephaloid tumor of the breast, in whom the administration of the tincture of eucalyptus was followed by phlegmonous swelling of the tumor, erysipelatous redness of the surrounding skin, mortification of the tumor, and rapid falling off of the eschars, accompanied with fever, lassitude, anorexia, furred tongue, headache, and delirium. The cicatricial remains of the tumor had a keloid appearance, and represented the stroma of the original disease. In spite, however, of the continued use of the tincture, this mass subsequently increased in size, and began to assume some doubtful signs of malignancy, when Prof. Luton substituted the powdered leaves of the eucalyptus, one gramme daily, for the tincture, and after three or four days the same phenomena of death of the tumor occurred as on the first occasion. The patient is still under observation, and hopes are entertained by the Professor that the case will terminate in complete cure.

The second case was that of a woman, sixty-eight years of age, suffering from symptoms of cancer of the stomach for nine months, and a tumor in the abdomen as large as a turkey's egg, to the left of the epigastrium, and apparently attached to the surrounding parts. She was ordered ten grammes of the tincture of eucalyptus daily, with divers interruptions, during five months, and at the end of that time the tumor had become much smaller, isolated and more movable, less firm in consistence, and more sensible to pressure; and at the same time the patient had lost the cachectic appearance, and appeared in better health. During the interruption in the administration of the medicine, the patient's sufferings were increased, and the return to it produced a marked amelioration. She is still under observation.

The third case was that of a man, fifty-three years of age, suffering from a tumor in the right hypochondriac and epigastric regions, and pre-

senting many of the subjective symptoms of cancer of the stomach. After three months' treatment by the tincture of eucalyptus, ten grammes daily, the patient was much better, and the tumor had diminished in size and consistence. He is still under treatment.

The fourth case was that of a man, 52 years of age, suffering from cancer of the stomach for ten and a half months, and in a much worse condition than the two preceding. In fact, he was reduced to an incredible state of consumption, by the incessant black vomiting, and was almost moribund. Ten-gramme doses of the tincture of eucalyptus were administered, with great relief to the symptoms for a short time, but the vomiting soon returned, and could only be controlled by subcutaneous injections of sulphate of soda. The patient is still under observation, and Professor Luton considers that his life has been considerably prolonged by the treatment.

The fifth case was that of a woman, 45 years of age, suffering from excessive metrorrhagia, uncontrollable by the usual hemostatics, with symptoms of cancer uteri in its early stage. The hemorrhage was completely controlled in less than eight days by ten grammes of the tincture of eucalyptus daily. After the relief of the metrorrhagia, the woman would not submit to an examination, so that there is some doubt about this case.

The sixth case was that of an old gentleman, nearly 80 years of age, who had had an epithelial cancer removed, by the knife, from the root of the nose; but the disease subsequently returned, and attacked the nose and angle of the right eye, producing a large ulcerating tumor, which bled excessively. The first dose of the tincture of eucalyptus produced a sensible effect, and after a very few more the tumor perished and was thrown off, leaving a large excavation with healthy granulations. The process of reparation proceeded most favorably, and was almost completed at the time of publishing the case.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—A pamphlet of 16 pages has reached us, containing two poems by Dr. W. T. Battles, of Shreve, Ohio. The first and longer is entitled, "Mrs. Adam, M.D.," a humorous, rhythmic commentary on woman as a physician. The second is an elegy on the death of Dr. A. Metz, whose meritorious writings, as well as high personal character, excited wide-spread regret at his sudden decease. The pamphlet can be had of the author.

THE
Medical & Surgical Reporter.

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M. D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	\$5.00
Half-Yearly Compendium of Med. Science,	3.00
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders be drawn to order of

D. G. BRINTON, M. D.,
115 South Seventh Street,
PHILADELPHIA, PA.

NUMBER 1000.

The present number of the MEDICAL AND SURGICAL REPORTER is the one thousandth time this journal has issued its regular edition to subscribers. With but one exception, this is an unparalleled life for an American medical periodical. The respectable *Boston Medical and Surgical Journal*, now in its ninety-fourth volume, we believe can display the most numerous trophies of longevity. Except it, not another medical publication has reached its millennial issue, until this week the REPORTER assumes this honor to itself.

A brief review of its life during this period will be an appropriate close to its first thousand editions.

Commenced at first as a local journal, the "organ" of the New Jersey State Medical Society, it was published in Burlington, in that State, under the supervision of a committee

appointed by the Society at its annual meetings. It is said that a council of war never fights; not less true is it that a committee of a society never edits. Consequently, the *New Jersey Medical and Surgical Reporter* found but an uncertain and languishing existence. To every appearance, it was to prove but one of those numerous literary progeny whose tenure on life is quite as slight as that of a foundling in an orphan asylum. Few struggle through the first three years, and a ten-year-old is truly an "infant phenomenon."

The committee, who, as usual, always had something else to do, transferred their charge to Dr. JOSEPH PARRISH, then residing in Burlington. He gave it careful attention, and prevented it from succumbing absolutely, though it remained far from promising a long or brilliant future.

About this time Dr. PARRISH associated with himself in practice Dr. S. W. BUTLER, then a young man, a graduate of the medical department of the University of Pennsylvania. The latter entered into the literary department of the office with unusual zeal; and when Dr. PARRISH left Burlington, in order to devote himself to the specialty of the treatment of inebriates, in which he has since become justly distinguished, Dr. BUTLER continued the publication with renewed enthusiasm.

Finally, in October, 1858, he risked the daring venture of changing the quarterly into a weekly, dropping the local prefix to the title of the journal, and removing its place of publication from Burlington to this city. In this enterprise he was aided by Dr. R. J. LEVIE, now one of Philadelphia's most eminent surgeons, to whose energy and literary skill much of the initiatory success of the undertaking was due.

Until the outbreak of the war success was rapid, and the subscription list indicated that constant lengthening so cheering to the editorial mind. But when that great catastrophe descended on the land, no interest felt it more sorely than scientific journalism. Never

at any time, however, was the publication of the *REPORTER* suspended. Though some irregularity was unavoidable, it yet maintained its existence in the midst of trials which overthrew nearly every other medical journal, North and South.

At the close of the conflict it rapidly regained its circulation; and as Dr. BUTLER had then its sole charge, he felt it fast increasing beyond his strength. He found much difficulty, however, in selecting a suitable assistant editor from among his acquaintances. Those whom he wished, could not leave their posts; those who could leave, were not qualified. At this juncture, a mutual acquaintance proposed the present editor, then unknown to Dr. BUTLER. A meeting was arranged, and in May, 1867, the names appeared jointly as editors.

The following year the *HALF-YEARLY COMPENDIUM OF MEDICAL SCIENCE* was commenced, under the joint editorship. Since then a regular and steady increase of the circulation of these periodicals has characterized each successive year.

In 1873 DR. BUTLER's health commenced to fail, tendencies to some lingering forms of phthisical disease developing themselves after a light attack of pneumonia. Early in the following year the present editor was left in sole charge of both publications.

He has to thank the kindness of the many professional friends for their continued support and oft-expressed approbation of his efforts to keep the *REPORTER* up to the high-water mark of journalism. Its pages are never sold; they are independent of societies, colleges, and publication houses. Free from all bias in such directions, they are equally so from local and personal prejudices, likes or dislikes. Scientific truth, especially that which concerns itself with the diagnosis and the treatment of disease, and the maintenance of professional solidarity, these are its aims. If they are accomplished, the main end will have been reached.

Journalism of this nature offers no prizes;

there is very little "money in it;" it is no pathway to fame; it involves heavy and constant labor for which there is no vacation, no suspension. Its recompenses are only evident to those who have an inborn turn for pen-work, and who find in such labor a congenial, self-remunerative employment. But, if honestly pursued, its results must be widespread and lasting; and this consideration is the best fruit it ripens.

NOTES AND COMMENTS.

Sexual Diseases in Virgins.

One of the most delicate and difficult positions of the young practitioner is when he is called to an unmarried woman, and, suspecting disease of the sexual organs, feels in duty bound to investigate the case. To one such the eminent gynecologist, Dr. Graily Hewitt, writes as follows, in a late number of the *British Medical Journal*:—

1. It is possible, by a carefully conducted digital examination *per rectum*, to obtain very valuable information as to the state of the uterus, in cases where a vaginal examination is not desirable. In a well marked case of flexion of the uterus, this method of examination reveals the fact to the observer without difficulty. This method, therefore, should be adopted in the first place, and the further steps to be taken will depend on circumstances. The presence of a long-standing fixed discomfort, referred to the pelvic region (disease of the bowel being excluded from consideration), justifies an exploration such as above mentioned. 2. Flexion of the uterus is not uncommon in unmarried women. 3. As regards the best treatment for it, that is a wide question; but I would state that if recent and slight, a positional treatment alone often gives satisfactory results. By "positional treatment," I mean maintenance of the recumbent position on the back or on the face, according as the flexion is forward or backward. When, however, the disease is of two or three years' standing, or severe, this treatment alone will not answer, and an internal mechanical treatment is indispensable. 4. The necessary mechanical treatment can be carried out, according to my experience, without in any way imperiling the moral health of the patient. 5. Chronic ill health, unfitness for the ordinary

enjoyments of life, and for undertaking the obligations of marriage, are the results of neglect of proper treatment in the bad cases. The curability is inversely as the duration of the malady.

The Longevity of Israelites.

Our readers will recall that this subject was discussed at considerable length in the *REPORTER* a year or two since. Dr. B. W. Richardson, of London, probably attracted by that correspondence, and also by the assertion that no Jew had died from cholera, has studied the subject carefully, and last month delivered a lecture on it. The result of his research has shown that, both on the Continent and in England, Jews possess a higher vitality than do the general community by whom they are surrounded. Tracing the causes for this greater longevity, the lecturer said he could not attach too much importance to the sanitary laws that obtained among the Jews, instancing those in regard to diet, cleanliness, and abstinence from strong drink. In fact, the Decalogue, from beginning to end, is one sanitary lesson, teaching them to subdue the passions which torment the brain and distress the body.

To Diminish Uterine Contractions.

The *Doctor* states that in cases where the contractions of the uterus are so strong as to prevent operative manœuvres, Dr. Frankel recommends the subcutaneous injection of hydrochlorate of morphia and sulphate of atropia in combination, in doses of from one and a half to eight centigrammes of the former, and from one to eight milligrammes of the latter. Five minutes after the injection inhalations of chloroform may be used with great benefit.

Diagnosis of the Sex of the Fœtus During Pregnancy.

Dr. Mattei asserts that a fœtus having 130 to 135 cardiac pulsations to the minute is generally a boy; those who mark 150 to 160 pulsations in the same time are girls. He was only mistaken in three instances, in which the girls were small and sickly. Probably this feeble condition was the cause of the slackening of the cardiac pulsations. The theory that the cardiac pulsations are more rapid in the female than in the male fœtus was started in 1859, by

Dr. Frankenhauser, of Berlin. Dr. James Cumming, of Edinburgh, from careful investigation of a number of cases, has found numerous exceptions; but believes that there seems to be a relation between the weight of the fœtus and its pulsations *in utero*, and that, for the weight, the pulsations are slower in the male than in the female.

NEWS AND MISCELLANY.

The Medical Law of California.

We make space, in spite of the crowded condition of our columns, for a copy of the Act, passed recently, regulating the practice of medicine in California. We are constantly receiving inquiries about these State laws, and believe it well that all should be laid before the profession. Our copy is supplied us through the kindness of Dr. N. C. Hamlin, of Yuba City. The text is as it appears on the enrolled bill in the Secretary of State's office. The enrolled law differs in many words from the engrossed bill as passed by the Legislature. The words inclosed in parentheses are in the original, and show the material changes.

An Act to Regulate the Practice of Medicine in the State of California. Approved April 3, 1876.

The people of the State of California, represented in Senate and Assembly, do enact as follows:—

SECTION 1. Every person practicing medicine, in any of its departments, shall possess the qualifications required by this Act. If a graduate of medicine, he shall present his diploma to the Board of Examiners herein named, for verification as to its genuineness. If the diploma is found genuine, and if the person named therein be the person claiming and presenting the same, the Board of Examiners shall issue its certificate to that effect, signed by all the members thereof, and such diploma and certificate shall be conclusive as to the right of the lawful holder of the same to practice medicine in this State. If not a graduate, the person practicing medicine in this State shall present himself before said Board and submit himself to such examinations as the said Board shall require; and if the examination shall be satisfactory to the Examiners, the said Board shall issue its certificate in accordance with the facts, and the lawful holder of such certificate shall be entitled to all the rights and privileges herein mentioned.

SEC. 2. Each State Medical Society incorporated and in active existence on the tenth day of March, 1876, whose members are required to possess diplomas or licenses from some legally chartered medical institution in good standing, shall appoint, annually, a Board of Examiners, consisting of seven members, who shall hold their

office for one year, and until their successors shall be chosen. The Examiners so appointed shall go before a County Judge and make oath that they are regular graduates, and (or?) licentiates, and that they will faithfully perform the duties of their office. Vacancies occurring in a Board of Examiners shall be filled by the society appointing it, by the selection of alternates or otherwise.

Sec. 3. The Board of Examiners shall organize within three months after the passage of this Act. They shall procure a seal, and shall receive, through their Secretary, applications for certificates and examinations. The President of each Board shall have authority to administer oaths, and the Board to take testimony in all meetings (matters?) relating to their duties. They shall issue certificates to all who furnish satisfactory proof of having received diplomas of (or?) licenses from legally chartered medical institutions in good standing. They shall prepare two forms of certificates; one for persons in possession of diplomas or licenses, the other for candidates examined by the Board. They shall furnish to the County Clerks of the several counties a list of all persons receiving certificates. In selecting places to hold their meetings, they shall, as far as is reasonable, accommodate applicants residing in different sections of the State, and due notice shall be published of all their meetings. Certificates shall be signed by all the members of the Board granting them, and shall indicate the medical society to which the Examining Board is attached.

Sec. 4. Said Board of Examiners shall examine diplomas, as to their genuineness, and if the diploma shall be found genuine, as represented, the Secretary of the Board of Examiners shall receive a fee of one dollar from each graduate or licentiate, and no further charge shall be made to the applicants; but if it be found to be fraudulent, or not lawfully owned by the possessor, the Board shall be entitled to charge and collect twenty dollars off the applicant presenting such diploma. The verification of the diploma shall consist in the affidavit of the holder and applicant that he is the lawful possessor of the same, and that he is the person therein named; and such affidavit may be taken before any person authorized to administer oaths, and the same shall be attested under the hand and official seal of such officer, if he have a seal. Graduates may present their diplomas and affidavits, as provided in this Act, by letter or by proxy, and the Board of Examiners shall issue its certificate the same as though the owner of the diploma was present.

Sec. 5. All examinations of persons not graduates or licentiates shall be made directly by the Board, and the certificates given by the Board shall authorize the possessor to practice medicine and surgery in the State of California; but no examination into the qualifications of persons not holding diplomas or licenses shall be made after December 31, 1876. After that date no certificates shall be granted by them, except to persons presenting diplomas or

licenses from legally chartered medical institutions in good standing.

Sec. 6. Every person holding a certificate from a Board of Examiners shall have it recorded in the office of the Clerk of the county in which he resides, and the record shall be indorsed thereon. Any person removing to another county to practice shall procure an indorsement to that effect on the certificate from the County Clerk, and shall record the certificate, in like manner, in the county to which he removes, and the holder of the certificate shall pay to the County Clerk the usual fees for making the record.

Sec. 7. The County Clerk shall keep, in a book provided for the purpose, a complete list of the certificates recorded by him, with the date of issue and the name of the medical society represented by the Board of Examiners issuing them. If the certificate be based on a diploma or license, he shall record the name of the medical institution conferring it, and the date when conferred. The register of the County Clerk shall be open to public inspection during business hours.

Sec. 8. Candidates for examination shall pay a fee of five dollars, in advance, which shall be returned to them if a certificate be refused. The fees received by the Board shall be paid into the treasury of the medical society by which the Board shall have been appointed, and the expenses and compensation of the Board shall be subject to arrangement with the society.

Sec. 9. Examinations may be in whole or in part in writing, and shall be of an elementary and practical character, but sufficiently strict to test the qualifications of the candidate as a practitioner.

Sec. 10. The Board of Examiners may refuse certificates to individuals guilty of unprofessional or dishonorable conduct, and they may revoke certificates for like causes. In all cases of refusal or revocation the applicant may appeal to the body appointing the Board.

Sec. 11. Any person shall be regarded as practicing medicine, within the meaning of this Act, who shall profess publicly to be a physician and prescribe for the sick, or who shall append to his name the letters "M. D." But nothing in this Act shall be construed to prohibit students from prescribing under the supervision of preceptors, or to prohibit gratuitous services in cases of emergency. And this Act shall not apply to commissioned surgeons of the United States army and navy practicing within the limits of this State.

Sec. 12. Any itinerant vender of any drug, nostrum, ointment, or appliance of any kind, intended for the treatment of diseases or injury, or who shall, by writing, or printing, or any other method, publicly profess to cure or treat diseases, injury or deformity, by any drug, nostrum, manipulation, or other expedient, shall pay a license of \$100 a month, to be collected in the usual way.

Sec. 13. Any person practicing medicine or

surgery in this State, without complying with the provisions of this Act, shall be punished by a fine of not less than \$50 nor more than \$500, or by imprisonment in the county jail for a period of not less than 30 days nor more than 365 days, or by both such fine and imprisonment, for each and every offence; and any person filing, or attempting to file, as his own, the diploma or certificate of another, or a forged affidavit of identification, shall be guilty of a felony, and upon conviction shall be subject to such fine and imprisonment as are made and provided by the statutes of this State for the crime of forgery.

Sec. 14. This Act shall take effect from and after its passage, but the penalties shall not be enforced till on and after December 31st, 1876.

The March of the Plague.

LONDON, April, 20.—The *Levant Herald*, of April 12, published at Constantinople, says that at Hillah, sixty miles south of Bagdad, from March 28th to the 31st, inclusive, there were 66 new cases of the plague and 42 deaths, and at Bagdad, from March 28th to April 1st, 145 new cases and 75 deaths. The plague has crossed to the left bank of the river Tigris, which had previously escaped it.

The first appearance of the plague in Mesopotamia was announced in an official telegram from Bagdad to Constantinople, dated February 20th. It stated that the presence of the epidemic had just been ascertained at Hillah, which is a town near the supposed site of ancient Babylon. A medical commission at once investigated the matter, and confirmed the first suspicions of Dr. Nicholaki, the Sanitary Officer at Hillah. Energetic measures were at once taken, both by the sanitary board of Constantinople and the authorities in Mesopotamia, to prevent the spread of the epidemic. The infected locality was completely cut off from intercourse with the surrounding towns and villages, and it was hoped that with proper precautions the disease would be confined within its present bounds. By the 30th of March, however, the terrible epidemic had reached Bagdad, and at the latest telegraph news, previous to that printed above—the 13th instant—it was increasing at Bagdad.

Texas State Medical Association.

The eighth annual session of the Texas State Medical Association met at Marshall, April 4. The Association was called to order at the appointed hour by the President, Dr. H. W. Brown, of Waco.

The attendance was quite large, all parts of the State being represented.

Dr. D. W. Yandell, of Louisville, was introduced by Dr. Johnson, and a hearty welcome was extended by President Brown, assuring him that his name was familiar to the fraternity of Texas.

Drs. J. A. Diddrell and S. W. Vahn, of the Arkansas State Medical Association, having arrived, were welcomed by the President.

Dr. John H. Pope read an able paper upon the science and progress of medicine.

The officers of the Association presented their reports.

Some interesting cases were reported, and their treatment, by Drs. Heard, Dowell, of Galveston, Kilpatrick, of Navasota, Ford, of Lynchburg, and Manning, of Waco.

Dr. Dowell read a paper on physical, physiological, and moral laws.

Officers elected for the ensuing year are: Dr. Harrison, of Columbus, President; Drs. Pope, of Marshall, Wiley, of Dallas, and Park, of Tyler, Vice-Presidents. Secretary East and Treasurer Larendon hold for five years.

Dr. Holcomb, of Ellis county, reported cases on the hip-joint disease.

Dr. Long, of Nacogdoches, reported a case, and its treatment, of chronic inflammation of the bladder.

Dr. Wooton read a paper on diseases of women.

The prize of one hundred dollars, offered last year by Dr. Heard for the best essay on the eucalyptus tree, was awarded to Dr. Bibb, of Austin. Dr. Heard paid the prize as soon as the decision was made.

Dr. Yandell delivered an able lecture before the Association.

The next meeting will be held in Galveston, on the first Tuesday in April.

Personal.

—Dr. Adolph Biornborg, an adjutant on the staff of Prince Murat during the wars of the First Napoleon, and commander of a cavalry squadron in the French army in 1812, died in Lawrence, Massachusetts, April 21st.

—Etienne Gauldinot, a Frenchman, living in Franklin township, Clermont county, Ohio, is the oldest man in the United States—so says the *Clermont Sun*. He was born March 19, 1752, in a little Canadian hamlet just below Quebec. He talks but little, but is able to walk about the room with a cane. He has never voted, and was not naturalized till 1851, when he took out his papers in Wheeling, Va.

—Dr. A. W. Washington, grand-nephew of General George Washington, the nearest living relative to the Father of his Country, and a resident of Denison, Texas, ships a box containing the following articles for exhibition at the Centennial: General Washington's court suit of brown silk, supposed to be the suit in which he was inaugurated. Ivory seal, set in gold, presented to Washington by General Lafayette. Sword presented to Washington by General Darks, the famous Indian fighter, before the Revolution. Knee and shoe buckles, and, most valuable of all, twelve autograph letters from General Washington to his brother Samuel, dated between 1772 and 1783, some from Mount Vernon and some from the field, and all giving Washington's private views of the war then waging.

—Dr. S. B. Ward, of New York city, has been appointed Professor of Surgery in Albany Medical College, in place of Dr. Armsby, deceased.

—Dr. Paul F. Eve requests that any contributions to surgery made by an American be forwarded to his address (Nashville, Tennessee) by July 4th, 1876. They are designed to be reported at the Centennial by the representative of that department of medicine.

Items.

—A well-known dentist in Paris has been arrested, accused of having, for four years past, while drawing and cleaning teeth, introduced slow poison into rich patients' mouths, at the instigation of their heirs, and thus committed many murders. Two hundred witnesses are said to have been subpoenaed.

—The question of "baby-farming," as carried on in Montreal, has been discussed by the Board of Health of that city. In this connection the subject of the disposal of foundlings came up, and it was shown that of 719 babies received at the Gray Nuns' Hospital last year, only 88 survived. Of the illegitimate children 44 belonged to Montreal and 47 were sent from the United States.

—In 1875, in London, 231 persons died of injuries by horses and vehicles in the public thoroughfares.

QUERIES AND REPLIES.

Hair Dye.

In reply to Wm. H. C.'s inquiry for a recipe for making hair dye that does not contain lead, I recommend him to try the following:—

R. Nitrate of silver,	drachm $\frac{1}{4}$
Aqua ammonias,	ounce ss
Rain water,	ounce j.

Mix, and apply with a small brush. J. A. I.

HAIR DYE WITHOUT LEAD.

R. Acid. gallic,	drachm }
Tinct. ferri mur.,	ounce }
Acid. acetic,	ounce }

Apply with a comb or brush. W. H.

OBITUARY.

DR. J. S. PARRY.

At a meeting of the Pathological Society of Philadelphia, held on Thursday evening, April 13th, 1876, the death of Dr. John S. Parry having been announced by the Secretary, it was unanimously

Resolved, That in the untimely death of our late Vice-President, Dr. John S. Parry, we have to deplore the loss of a valued officer of the Society, and of a colleague whose zealous devotion to the promotion of pathological science, and whose sterling personal qualities have secured the lasting admiration and regard of all his fellow-members.

That the Secretary be requested to transmit a copy

of this resolution to the family of Dr. Parry, and to have it published in the medical journals of this city.

THOMAS G. PORTER, JR.,
Secretary.

MARRIAGES.

BACHE-PEACE.—On the 20th ultimo, Lieutenant Alfred B. Bache, U. S. A., and Anna, daughter of Dr. Edward Peace, of this city.

BRADFORD-LEVERICH.—In New York city, on Thursday evening, April 13, by Rev. Dr. John Hall and Rev. John P. Knox, Theo. Dwight Bradford, M. D., and Tillie Rose Leverich, daughter of the late Charles P. Leverich.

BOWMAN-HAMILTON.—In New York city, on Thursday, April 20, 1876, at the residence of the bride's parents, by Rev. Dr. Rylance, Mary, daughter of James Hamilton, and John R. Bowman, M. D., of Cheyenne, Wyoming Territory.

CROCKER-WATKINS.—In New York city, on Tuesday, April 18, 1876, at the Church of the Divine Paternity, by Rev. Dr. E. H. Chapin, Wm. Atwell Crocker, M. D., and Addie E., only daughter of the late Osmer S. Watkins.

WHELEN-SMITH.—On the 20th instant, at the Church of the Epiphany, by the Rev. Richard Newton, D. D., Dr. Alfred Whelen and Sarah W., daughter of Thomas D. Smith, all of this city.

STEVENSON-LINSEY.—Tuesday, April 4th, at the residence of the bride's parents, by Rev. R. Kerr, A. C. Stevenson, M. D., of Oakdale, Pa., and Miss Irene Linsey, of Miller's Run, Washington Co., Pa.

ELSBERG-LOOMIS.—On April 26th, at St. James' Church, New York city, Dr. Louis Elsborg and Mary V. H. Scoville, daughter of Mr. and Mrs. Frank Loomis.

THOMAS-TURNBULL.—At St. Luke's Church, April 18, 1876, at 8 P. M., by the Rev. C. George Currie, Charles M. Thomas, M. D., and Marion Elmale, daughter of Laurence Turnbull, M. D.

DEATHS.

BESSE.—In this city, on the 20th instant, Dr. P. Emilio Besse, in the 28th year of his age.

BONNER.—In this city, Monday morning, April 2d, at twenty minutes past five, Stephen Bonner, M. D., after a lingering illness, aged 67 years.

BUSTEED.—In New York city, on Monday, April 10th, Professor John Busteed, M. D., in the 62d year of his age.

BRYANT.—In this city, on Sunday, April 16, and after a lingering illness, Dr. G. W. N. Bryant, aged 64 years.

FINCH.—At New-Rochelle, N. Y., April 19th, Harriet Beyea, wife of E. W. Finch, M. D., and daughter of the late Samuel Beyea, of Goshen, N. Y.

HARRISON.—Fell asleep in Jesus, on Friday, 21st instant, at 2:45 P. M., William David Harrison, M. D., aged 30 years, of this city.

HASBROUCK.—In Jersey City, on Thursday evening, April 13th, Sarah S., daughter of Dr. Stephen Hasbrouck.

HOUGHTON.—At Hartford, Conn., on Thursday, March 23d, Roland S. Houghton, M. D., entered into rest.

LIVEZEY.—In this city, on the morning of the 15th instant, after a short illness, Edward Livezey, M. D., in the 43d year of his age.

MATTE.—At Glenwood, Rockbridge county, Va., Thursday morning, 30th, 1876, Margaret L., wife of William F. Matte, and daughter of Thomas R. Crittenden, M. D., Dover N. J., aged 24 years.

MORGAN.—In Haverhill, Vt., April 7th, Dr. Hiram Morgan, aged 71 years.

RIPLEY.—In New York city, on Tuesday, April 11, 1876, of diphtheria, Henry Johnston, youngest child of Dr. John H. and Isabelle M. Ripley, aged 1 year and 7 months.